

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 26 1960

-60-034465

DED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 955A STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield, Mo.</u>		Length of stay in 1b <u>minutes</u>		c. CITY OR TOWN <u>Clinton twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt. 4, Mt. Grove</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sherroll</u> Middle <u>Ock</u> Last <u>Simmons</u>				4. DATE OF DEATH <u>Sept-14-1960</u> Month <u>Sept</u> Day <u>14</u> Year <u>1960</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-38</u>		
9. AGE (last birthday) <u>22</u>		IF UNDER 1 YEAR Months <u>22</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultry plant empolyee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry</u>		
11. BIRTHPLACE (City and state or country) <u>Mt. Grove, Mo.</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>				
13a. FATHER'S NAME <u>Leo Simmons</u>				13b. MOTHER'S MAIDEN NAME <u>Alice Dowdy</u>		14. NAME OF HUSBAND OR WIFE <u>Glenda Simmons</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>VOS</u>				16. SOCIAL SECURITY NO. <u>000-00-0000</u>		17. INFORMANT <u>Leo Simmons, Rt. 4, Mt. Grove, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO (b) <u>Severe Cerebral Concussion</u> DUE TO (c) <u>8 hrs.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Car struck 2 trucks, then crashed over an emb-</u>				
20c. TIME OF INJURY <u>12:15</u> Hour <u>12</u> a.m. <u>15</u> p.m.		Month, Day, Year <u>9-14-60</u>		anlcmont.				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hi way 60 4 1/2 Mi. N of Cabool</u>		20f. CITY, TOWN, OR LOCATION <u>Clinton, twp.</u>		COUNTY <u>Texas</u> STATE <u>Mo.</u>		
21. I attended the deceased from <u>1:00 AM 9-14-60</u> to <u>6:30 AM 9-14-60</u> and last saw him alive on <u>9-14-60</u> Death occurred at <u>8 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Joe A. Wall MD</u> (Degree or title)				22b. ADDRESS <u>Houston, Missouri</u>		22c. DATE SIGNED <u>9-17-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>		23b. DATE <u>9-14-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Penner Cemotery</u>		23d. LOCATION (City, town, or county) (State) <u>Douglas County, Mo.</u>		
24. FUNERAL DIRECTOR <u>Elliott Contry, Cabool, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>9-21-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie B. Melton</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 22 1960

SEP 27 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.